

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-041111

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 2997

1. PLACE OF DEATH a. COUNTY <u>ST LOUIS</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>DAKS</u>		c. CITY OR TOWN <u>St. Louis</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Gravois Rest Haven</u>		d. STREET ADDRESS (If outside, give location) <u>6517 Leona</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Elizabeth Nicolay</u>		4. DATE OF DEATH Month Day Year <u>Oct. 16, 1962</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 8, 1876</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	9. AGE (last birthday) <u>86</u> IF UNDER 1 YEAR Months Days Hours Min.
11a. FATHER'S NAME <u>Geo. Neumann</u>		11b. MOTHER'S MAIDEN NAME <u>Agatha Hoffmann</u>	
12a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		12b. SOCIAL SECURITY NO. <u>none</u>	
13a. FATHER'S NAME <u>Geo. Neumann</u>		13b. MOTHER'S MAIDEN NAME <u>Agatha Hoffmann</u>	
14a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		14b. SOCIAL SECURITY NO. <u>none</u>	
15. FATHER'S NAME <u>Geo. Neumann</u>		15b. MOTHER'S MAIDEN NAME <u>Agatha Hoffmann</u>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16b. SOCIAL SECURITY NO. <u>none</u>	
17. FATHER'S NAME <u>Geo. Neumann</u>		17b. MOTHER'S MAIDEN NAME <u>Agatha Hoffmann</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchio-Pneumonia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Arterio-Sclerotic-Cardio-Vascular Disease</u>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE		
21. I attended the deceased from <u>Aug 1962</u> to <u>10-16-62</u> and last saw him alive on <u>10-3-62</u> Death occurred at <u>9 a.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.	22a. SIGNATURE (Degree or title) <u>Allen M. Hearnsey M.D.</u>		
22b. ADDRESS <u>860 N Woodlawn</u>	22c. DATE SIGNED <u>10-17-62</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>10-19-62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Sunset Burial Park</u>	23d. LOCATION (City, town, or county) (State) <u>St. Louis County, Mo.</u>
24. FUNERAL DIRECTOR <u>Southern Funeral Home</u>	25. DATE RECD. BY LOCAL REG. <u>10-17-62</u>	26. REGISTRAR'S SIGNATURE <u>John B. Murphy M.D.</u>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

USE BLACK INK
OR
TYPEWRITER RIBBON

VS 300
Rev. 4/59

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Dr. Allen Mc Neary
860 N. Woodlawn

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

Harmon C. Hill

Licensed Embalmer No.

4347

P. O. Address

St. Louis Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting:

If this body is not embalmed, fact should be so stated above.